STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN46203

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F0000	This visit was for the Post Survey Revisit to the Investigation of Complaint IN00092695 completed on 07-07-11. This visit was in conjunction with the Investigation of Complaint IN00094742. Complaint IN00092695 - not corrected. Survey dates: August 16, 17, 18, & 19, 2011 Facility Number: 004700 Provider number: 155741 AIM number: 100266630 Survey team: Mary Jane G. Fischer RN Census Bed Type: SNF/NF: 42 Total: 42 Census Payor Type: Medicare: 2 Medicaid: 34 Other: 6 Total: 42 Sample: 6 Supplemental Sample: 10	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0241 SS=D	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/26/11 by Suzanne Williams, RN The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure the dignity of a resident, in that when a dependent resident required the use of a positioning device, the facility staff allowed the positioning device to be torn and soiled while in use. In addition, when residents requested and required the assistance of facility staff for bathing/showering, the facility staff did not assist the residents. The affected 3 of 6 resident reviewed for dignity in a sample of 6. [Residents "D", "N" and "E"]. Findings include: 1. The record for resident "D" was reviewed on 08-17-11 at 1:05 p.m. Diagnoses included but were not limited to senile psychotic condition, bipolar disorder and hemiplegia. These diagnoses remained current at the time of the record review.	F0241	Residentt D had ttheir worn wedge cushion replaced immediattely upon observatton, tthen since has been replaced witth a scoop mattress Residentt N received a shower by early evening and discharged tto home on 8/19/11. The C.N.A. who flailed tto give Residentt N tthe shower in a ttmely manner received an employee memorandum flor nott complettng her assignmentt and a residentts requestt as expectted Residentt E has received showers on a regular basis. The residentt afler assisttance tto tthe shower chair does requestt tthe aide sttep outt while he showers and does nott always allow skin checks. The Administrattor in flacttsaw tthe residentt in tthe shower on one ofl tthe days ofl tthe survey. The documenttatton tto supportt tthis however, is lacking as tthe residentt does nott allow a flull skin check during his showers. All shower sheetts will be signed by tthe charge nurse, ongoing, and given tto tthe Directtor ofl Nursing flor auditting daily	09/15/2011

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	Review of the 05-31-11 Minimum Data Set assessment indicated the resident was total care for bed mobility and was incontinent of bowel and bladder. During an observation on 08-18-11 at 11:00 a.m., the resident was in bed. During this observation, a blue foam wedge cushion had been placed behind the resident's head. The edges of the foam wedge were torn and tattered. In addition, there were multiple brown smears of an unknown substance which spanned the top edge of the positioning device. 2. During an observation on 08-18-11 at 9:00 a.m., Resident "N" indicated "Could I get a shower this morning ? I'm going home tomorrow so I thought I would ask for one today." During this observation the resident stood at the nurses station in her bathrobe. The resident's hair appeared oily and separated into strands. The Director of Nurses responded to the resident request and indicated she would inform the nursing staff. Review of the resident's plan of care, dated 07-14-11 indicated the resident "needs assist with ADL's [activities of daily living] due to weakness related to cancer diagnosis." During an observation on 08-18-11 at		ttmes 4 weeks, tthen 3ttmes a week flor4 weeks, tthen 1ttme a week flor an addittonal montth. All residentt shower sheetts will be keptt on each residentt and will be used tto do random checks tto ensure tthe residentt received ttheir scheduled shower in a ttmely flashion. The Directtor ofl Nursing or Designee will conductt5 random observattons ofl residentt showers based on tthe enttre residentt shower listt weekly flor 12 weeks, tthen random check will be ongoing flor appropriatte residentt grooming. All sttafl will be inserviced on Septtember15, 2011 on tthe importtance ofl documenttatton ofl all care tthatt has been provided tto tthe residentts, including ttmely documenttatton ofl shower sheetts tto ensure accuracy ofl observattons while preserving a residentts dignitty . All residentts in tthe flacilitty are identtfled as having pottenttal tto be aflectted An all sttafl inservice will be held on Septtember15, 2011 tto emphasize tthe importtance ofl residentt dignitty as itt relatted tto tthe qualitty and ttmeliness ofl tthe care tthatt is provided. Timely documenttatton ofl care given will also be emphasized, and tthe deflnitton ofl neglectt will be reviewed witth all sttaflDuring	

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	3:15 p.m., the resident was seated on the side of the bed. The resident remained in the bathrobe and appeared unkept as previously observed. The resident indicated she still had not received her shower. 3.) The record for resident "E" was reviewed on 08-17-11 at 12:45 p.m. Diagnoses included, but were not limited to, diabetes mellitus, obesity, anemia and hypertension. These diagnoses remained current at the time of review. Review of the 06-20-11 Minimum Data Set assessment indicated the resident required the assistance of one staff member for bathing. The resident's plan of care, dated 09-21-10 indicated the resident needed assistance with ADL's due to impaired mobility. Interventions to the plan of care indicated "assist resident to shower twice weekly." Review of the CNA assignment sheet indicated the resident received showers on Monday and Thursday. During an observation on 08-17-11 at 9:25 a.m. Resident "E" was seated in a wheelchair. As licensed practical nurse employee #2 removed the Kerlix from the		weekly wound rounds observattons will be made ofl any body pillows, mattresses, gap fllers, ofl loading equipmentt heel floatters, wedge cushions, and otther devices used in tthe bed will be notted by tthe wound nurse and communicatted tto tthe Directtor ofl NursingThe Administtrattor and Directtor ofl Nursing will make rounds once weekly ttmes 6 weeks, tthen once weekly flor6 weeks and ongoing montthly Communicatton florms will be used by all sttafl tto tthe Administtrattor,Directtor ofl Nursing and/or Mainttenance Supervisor flor repair or replacementt ofl equipmentt or ittems tto ensure tthatt residentts have equipmentt tthatt is nott worn broken, soiled, and tthatt tthe residentts are cared flor in a manner tthatt preserves ttheir dignitty and individualitty.All communicatton florms will be monittored by tthe Administtrattor in each ofl tthe morning meettngs and tthe appropriatte intterventtons will be provided ttmely flor6 weeks, tthen 3ttmes a week flor 6 weeks. This communicatton and ttmely intterventtons will be ongoing The monittoring ofl equipmentt will be reviewed in tthe SWAT(Skin, Weightt, nuttritton,Accidentt, flalls, and Therapy services) meettngs on each Tuesday witth tthe intterdisciplinary tteam flor possible	

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	resident's left lower leg/stump, the resident's skin was bright red from the calf to the knee and grayish/brown from the calf to the stump area. The skin appeared peeling. The licensed nurse indicated "It looks like dried skin - it has to be washed and there's an area right here that looks suspicious. I need to get a basin of water and wash that up real good before I lotion it up." During interview on 08-17-11 at 12:00 p.m., the Director of Nurses indicated she was unable to find documentation when the last time the resident had received a shower. 4.) Review of the facility information related to "neglect," and undated indicated the following: "Neglect - What is neglect ?" "Neglect: The failure to exercise that degree of care that a reasonable person in a care providing capacity would exercise such as failure to assist in personal hygiene, provision of food, clothing or shelter, provision of medical care or to protect from health and safety hazards or to prevent malnutrition or dehydration." This federal deficiency was cited on 07-07-11. The facility failed to implement a systemic plan of correction		additional interventions or use of appropriate equipment for 12 weeks, then ongoing The review from the rounds and SWAT meetings will be discussed at the quarterly QA meetings, ongoing, for additional input from the Physician and Pharmacist for updates of items and equipment available Resident dignity will be discussed at the QA meetings no less than quarterly The Director of Nursing and Administrator are responsible for compliance. Date of completion September 15, 2011	

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	to prevent recurrence. 3.1-3(t)			
F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to ensure a plan of care was developed for a resident, in that when a resident had a tracheostomy, feeding tube, respiratory treatments, and required suctioning, with specific advanced directives and residents with a history of falls, the facility failed to ensure a plan of care was developed for 4 of 6 residents reviewed for care plans in a sample of 6. [Resident "A", "B", "E", "I"].	F0279	Resident A has had a new fall risk assessment completed. Her care plan, C.N.A. Assignment Sheet, physicians orders, and resident door have been updated to reflect current interventions to prevent falls. She now uses a non-alarming seat belt when she is up in her wheelchair. All licensed nurses will be inserviced no later than September 15, 2011 on the importance of making sure all fall prevention interventions are in place for each resident as ordered. Additionally, the inservice will review the	09/15/2011

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	Findings include: 1. The record for resident "A" was reviewed on 08-16-11 at 11:15 a.m. Diagnoses included, but were not limited to, senile/presenile dementia, schizophrenia, depressive disorder, seizure disorder and contractures. These diagnoses remained current at the time of the record review. During the initial tour of the facility on 08-16-11 at 9:15 a.m., with Licensed practical nurse employee #2 in attendance, the resident was observed in bed. The resident had significant bruising beneath both eyes and a large knot on the forehead. The licensed nurse indicated "[name of resident] just got out of the hospital." The resident indicated "I fell out of my wheelchair and I don't know how." Review of the resident's plan of care, dated 04-14-11 indicated the resident had the "potential for injuries from falls due to history of falls, poor mobility and use of antidepressant and anti seizure medications." Interventions included "staff to assure environment is free of wet spots and small items placed low on floor, assure that lighting is adequate, and monitor for side effects from medications as cause for		importance of updating care plans after falls. The care plan for Resident B has been revised to include nursing care related to needs associated with respiratory care/presence of tracheotomy. This care plan includes the specific size and type of equipment used, and addresses feeding tube as well. Resident B's code status has been verified and his care plan and physician orders have been updated to reflect that Resident B is a 'full code.' Resident E has had a new fall risk assessment completed. His care plan, C.N.A. Assignment Sheet, physicians orders, and resident door have been updated to reflect that he is not at high risk for falls. Resident I has been re-assessed for fall risk and scored 8, not at risk for falls. She does not need an alarm device for fall prevention. C.N.A. Assignment sheet and care plan have been corrected to indicate that no alarms are used. All residents in the facility have been identified as having potential to be affected. An inservice will be given to the SSD and all licensed nurses regarding what they must look for in the papers that return from the hospital to the facility regarding who has the authority to make decisions on a resident's behalf. In the papers from the hospital, the SSD or charge nurse must look for documentation regarding code status, guardianship, powers of attorney,	

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	falls." Review of the Minimum Data Set assessment dated 04-28-11 indicated the resident was total care for transfer and at risk for falls due to dependent on staff for ADL's [activities of daily living] and not being ambulatory. The "Physical Restraint Order" log for July 2011 indicated "Restraint Order - wheelchair seat belt due to dementia. Release q [every] 2 h [hours]." Review of the nurses notes, dated 07-30-11 at 5:30 p.m., indicated "Pt. [patient] found lying on floor on right side beside w/c [wheelchair]. Supper try on bed table. Pt. alert verbal. Lg [large] hematoma on res. [resident] forehead. BP [blood pressure] 160/112, T [temperature] 98 degrees, P [pulse] 100, R [respirations] 20, O2 sat. [oxygen saturation level] 76 %." The licensed nurse notified the resident's physician who gave instructions to send the resident to the local area hospital emergency room. The resident returned from the hospital emergency room on 07-30-11 at 11:15 p.m. A review of the occurrence report, dated 07-30-11 indicated the resident had injury		and what relatives were contacted while the resident was in the hospital. The inservice will present to the staff a new policy/procedure entitled Health Care Consent for an Incapacitated Resident, which describes who has the authority to make decisions on a resident's behalf per Indiana law. The Social Service Designee will audit the code status for every resident in the building monthly X 3 and then quarterly X 3 and then annually thereafter. In this audit, the SSD will verify that the code status paper that the resident/responsible party has signed also has the physician's signature, and that the code status indicated on that form agrees with the marking on the outside of the chart, the physician's order section of the chart, and the care plan. The SSD will report to the QA Committee the results of the audits at the regularly scheduled QA meetings. The Administrator are responsible for compliance. Date of completion September 15, 2011ADDENDUM: By September 15, 2011, a new fall risk assessment were completed for all residents residing in the facility. After these assessments are completed, the interdisciplinary team will decide what interventions are appropriate for the residents at high risk for falls. The CNA Assignment Sheets, care plans,	

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	to the center of face, lip, and mouth. The "root cause" was noted as "due to resident action or internal risk factors, position when found - lying in fetal position on right, alarm - not sounding." Review of the facility "Investigation of Injuries of Unknown Origin," on 08-16-11 at 12:00 p.m., and undated indicated the following: "Policy [bold type and underscored] To promptly investigate resident injuries of unknown origin." "Purpose [bold type and underscored] To develop preventive strategies and interventions to prevent further injury." "Procedure [bold type and underscored] "6.) An acute care plan shall be developed to address the injury and to prevent any further injuries." Upon the return of the resident to the facility, the nursing staff failed to develop an "acute care plan" to address the needs of the resident, in regard to the fall in which the resident sustained extensive facial bruising. 2. The record for resident "B" was reviewed on 08-16-11 at 1:20 p.m. Diagnoses included, but were not limited		physicians orders, and resident door markings will be updated to indicate the current interventions to prevent falls. The Administrator or designee will audit alarms and other fall prevention interventions three times weekly X 4 weeks. If compliance is maintained after four weeks, audits will reduce to once weekly X 3 months and then once monthly thereafter on an ongoing basis. If compliance is not maintained after four weeks, the audits will continue to be done three times weekly until compliance is achieved. The results of these audits will be discussed at the QA meetings not less than quarterly on an ongoing basis. The Administrator is responsible for compliance. Date of completion September 15, 2011	

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	to, anoxic brain injury, seizures, persistent vegetative state, ventilator associated pneumonia, respiratory failure, and spastic quadriplegia. These diagnoses remained current at the time of the record review. The clinical record indicated the resident had a tracheostomy and a percutaneous endoscopic gastrostomy feeding tube at the time of admission to the facility. Review of the "Nursing Admission Assessment," dated 07-22-11 at 6:45 p.m., included an initial care plan. However, this care plan lacked specifics for the resident or nursing interventions related to needs associated with respiratory care and lacked an assessment of the "chest/lungs" related to breath sounds to include rales, rhonci, wheezes or cough. The assessment indicated the resident had a size #6 Shiley tracheostomy. The record indicated the resident returned to the facility on 08-01-11. Record review on 08-16-11 at 1:20 p.m. lacked a plan of care that addressed the specific needs of the resident's tracheostomy brand, size, cuffed or uncuffed, if the tracheostomy had an inner cannula [disposable or nondisposable], fenestrated or nonfenestrated, or the nebulizer treatments.			

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	In addition, the resident had a PEG tube for feeding. Review of the plan of care, dated 08-12-11 indicated the resident was at "risk for aspiration. Needs feeding tube due to inability to take anything by mouth." Interventions to this plan of care instructed the nursing staff to "Change tube and tubing as ordered." Review of the hospital discharge summary indicated the following: "We did have several discussions regarding code status with this patient. There were several disagreements between the patient's [spouse] and the patient's siblings. The [spouse] was insistent on having everything done for the patient and maintaining FULL CODE status." The hospital records indicated the resident's spouse was the Power of Attorney. The resident had a change of condition on 07-25-11, and was transported to the local area hospital. Review of the physician re-write, for re-admission to the facility the licensed nurse documented the resident was a DNR [Do Not Resuscitate]. When interviewed on 8/16/11 at 3:10 p.m., licensed nurse employee #5 verified that			

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	she recorded the order from the hospital record. When further interviewed if the code status was verified with the resident's spouse, the licensed nurse indicated "no, I just wrote the orders." Further review of the resident's chart contained a document titled "Out of Hospital Do Not Resuscitate Declaration," dated 08-01-2011 by the resident's sibling. The resident's plan of care dated 08-12-11 indicated the resident was a DNR. "Resident/Responsible party has made wishes clear to NOT receive C.P.R. [cardiopulmonary resuscitation] and MD has signed approval." A review of the Social Service notation, dated 08-15-11 indicated, "Met with [name of resident's sister] who provided court papers showing [family member] is petitioning for guardianship and [family member] stated did not want [resident's spouse] involved in care. [Spouse is expected to contest this. Hearing is scheduled for August 31 at 11:30 a..m. Conflict on who speaks for [name of resident] will hopefully be settled at that time. [Spouse] has been in once, to my knowledge and has not insisted on being responsible party, to the best of my knowledge."			

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	During an interview on 08-16-11 at 1:00 p.m. the Social Service Director indicated he thought it would be alright to make the resident a NO CODE until the time of the hearing. When interviewed if he spoke with the resident's spouse regarding the code status, the Social Service Director indicated "no." In addition, the resident was identified as a HIGH FALL RISK per the assessment dated 08-01-11. The record lacked a plan of care to address this concern or provide interventions. 3. The record for Resident "E" reviewed on 08-17-11 at 12:45 p.m. The resident had bilateral amputation of both feet. The resident was identified as a fall risk on the CNA assignment sheet. A review of the "Fall Risk Assessment, dated 06-20-11 indicated the resident scored an "8." The assessment indicated the resident was not at HIGH RISK for falls. The door to the resident's room lacked a "leaf or waterfall" which would have identified the resident as a fall risk. Review of the resident's record lacked a plan of care to address the resident as a fall risk, as indicated on the CNA assignment sheet. 4. The record for Resident "I" was			

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	155741	A. BUILDING 00 B. WING	08/19/2011

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	reviewed on 08-19-11 at 2:10 p.m. The resident was identified with a PSA [Personal Safety Alarm] in the wheelchair. During an observation on 08-17-11 at 11:00 a.m., with the Administrator in attendance, the resident did not have the required device. A review of the "Fall Risk Assessment, dated 04-18-11 indicated the resident scored a "10." The assessment indicated the resident was at HIGH RISK for falls. In addition, the door to the resident's room lacked a "leaf or waterfall" which would have identified the resident as a fall risk. Review of the resident's record lacked a plan of care to address this concern. This federal deficiency was cited on 07-07-11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(a) 3.1-35(b)(1)			
F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to ensure	F0309	Resident E has obtained a treatment order for his skin issues	09/15/2011

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	the necessary care and services were provided for a resident with wounds, and that the resident attained the highest practical physical care for the wounds, which did not diminish or deteriorate, in that when the condition of a resident's lower legs worsened, and a new open area had developed, the nursing staff failed to ensure appropriate care, for 1 of 3 residents reviewed for open areas in a sample of 6. (Resident "E") Findings include: The record for resident "E" was reviewed on 08-17-11 at 12:45 p.m. Diagnoses included, but were not limited to, diabetes mellitus, obesity, anemia, non healing surgical wounds (bilateral stumps) and hypertension. These diagnoses remained current at the time of review. Review of the resident's plan of care, dated 08-08-11, indicated "Risk for infection of surgical site. Location, bilateral feet. Resident has a stasis ulcer on right leg. (Has bilateral stumps - no toes." Interventions included "Treatment as ordered, report any drainage to MD [Medical Doctor], Wound clinic." During an observation on 08-17-11 at 9:25 a.m. Resident "E" was seated in a wheelchair.		on his lower legs. Licensed Nurse #2 was responsible for monitoring wounds during daily dressing changes and skin treatments for all residents on Resident E's unit. Licensed Nurse #2 no longer works at this facility. All residents in the facility that have skin breakdown are identified as having potential to be affected. The designated Wound Nurse will conduct wound rounds each Wednesday including measurements, any changes, any new treatments needed, and notifications as required. The Director of Nursing will review documentation from the wound rounds by the next business day after the rounds have been performed. All nurses will be inserviced by September 15, 2011, on the importance of physician notifications for changes in a resident changes in condition, including skin changes. Also, a review will be given on Policy and Procedures for obtaining timely treatment orders for new skin issues identified or if no improvement has been observed	

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	Licensed nurse employee #2 removed the dressing to the right lower leg. The dressing was dated 08-16-11. The dressing was observed to contain bloody and yellow drainage. The resident's lower leg was bright red from the stump to the knee. The Nurse indicated the open area on the underneath side of the stump measured 5.2 cm [centimeters] in length, 3.6 cm width and 0.4 depth. The licensed nurse explained she cleansed and then wiped the area with Santyl and Gentamycin and then applied calcium alginate in wound bed. The licensed nurse then applied LacHytrin lotion to the lower extremity and stump, wrapped the lower leg with kerlix, and then applied an ACE wrap over the kerlix. The licensed nurse then removed the Kerlix from the resident's left lower leg/stump, the resident's skin was bright red from the calf to the knee and grayish/brown from the calf to the stump area. The skin appeared peeling. The licensed nurse indicated "It looks like dried skin - it has to be washed and there's an area right here that looks suspicious. I need to get a basin of water and wash that up real good before I lotion it up." After the nurse cleansed the left lower leg/stump, the nurse measured the "suspicious area." The licensed nurse indicated the area measured 1.2 cm by 1.0		with a particular treatment after 2 weeks. The licensed nurses will be inserviced on additional wound and skin protocol to follow if the wound nurse is unavailable. The Director of Nursing will review all physicians' orders, wound rounds, and old and new treatments Monday through Friday, with weekend review discussed at the morning meeting on Mondays, for 4 weeks and weekly for 3 additional months or until 100% compliance is met. Weekly reviews will be ongoing with a new SWAT meeting which will include skin, weights/nutrition, accidents/falls, and therapy services. C.N.A.s will be inserviced on September 15, 2011 on prevention of skin breakdown and on prominent areas to watch for early signs of skin breakdown. They will be given a diagram post test to show they have understanding the areas of potential skin breakdown. Weekly reviews will be ongoing with a new SWAT meeting which will include skin, weights/nutrition, accidents/falls, and therapy services. The DON and the designated Wound Care nurse will visit with the Westview Wound Care Center to discuss partnering for continuity of resident wound care. All skin issues, notifications, staff compliance and review of wound center care provided will be discussed in the monthly QA	

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	cm by < [less than] 0.1 cm. Review of the nurses notes prior to 08-17-11, lacked documentation of the condition/color of the resident's legs or the new open area. 3.1-37(a)		meetings times 3 months and ongoing. Care plans will be updated with each new skin issue and applicable treatment. These will be reviewed by the Administrator and Director of Nursing at the newly formed interdisciplinary SWAT meeting to be held on each Tuesday and will include skin, weights/nutrition, accidents/falls, and therapy services. The Administrator will audit the SWAT meetings weekly for 4 weeks times 1 month, then 2 weeks for 2 months, or until 100% compliance is met, but will be ongoing. Any staff not performing their duties will be disciplined for not following facility procedures. All issues discussed in the SWAT meetings will be discussed at the monthly meetings times 3 months, then ongoing to ensure no new issues arise. The Administrator will also discuss his audits of the SWAT meetings with the Physician and Pharmacy representative present at the quarterly QA meetings and will be added to the QA agendas. The Directtor ofl Nursing and Administtrattor are responsible flor compliance. Datte ofl completton Septtember 15,	

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